Market Conduct Report

Time Insurance Company
John Alden Life Insurance Company
Union Security Insurance Company

December 10, 2010

Connecticut Insurance Department

TABLE OF CONTENTS

Time Insurance Company
John Alden Life Insurance Company
Union Security Insurance Company

I. INTRODUCTION

An examination of Time Insurance Company, John Alden Life Insurance Company and Union Security Insurance Company (hereinafter referred to as the "Companies") was conducted by Market Conduct examiners of the State of Connecticut Insurance Department at the Department's office in Hartford, Connecticut.

II. SCOPE OF EXAMINATION

From June 22, 2009 through April 5, 2010, the Market Conduct Division of the Connecticut Insurance Department examined the market conduct practices of the Companies using a sample period of January 1, 2006 through March 31, 2009. The examination was limited to Connecticut business.

The purpose of the examination was to evaluate the Companies' market conduct practices and treatment of certificate holders in the State of Connecticut. The examination focused on the solicitation of new business, marketing and sales, agent licensing and appointments, underwriting and rating, certificate holder service, complaint handling, claim processing and company operations.

The market conduct examination was conducted pursuant to Connecticut Insurance Department policies and procedures, and the standards proposed in the NAIC Market Regulation Handbook.

III. COMPANY PROFILE

The market conduct examination included the review of Time Insurance Company, John Alden Life Insurance Company and Union Security Insurance Company. Each company is organized as a stock company. Time Insurance Company was incorporated in 1910 and its principal place of business is Milwaukee, Wisconsin; John Alden Life Insurance Company was incorporated in 1973 and its principal place of business is Milwaukee, Wisconsin; Union Security Insurance Company was incorporated in 1910 and its principal place of business is Kansas City, Missouri. The Companies are licensed to write business in Connecticut.

Direct premiums written as of December 31, 2009 were as follows:

Time Insurance Company

	Connecticut	Total (All States)
Life	212,405	3,155,665
Annuity Considerations	0	0
Accident & Health	11,304,274	1,309,755,162

John Alden Life Insurance Company

	Connecticut	Total (All States)
Life	37,434	4,569,334
Annuity Considerations	0	0
Accident & Health	3,463,641	482,914,676

Union Security Insurance Company

	Connecticut	Total (All States)
Life	1,165,858	213,999,826
Annuity Considerations	7,992	159,210
Accident & Health	9,071,017	886,159,063

Time Insurance Company, John Alden Life Insurance Company and Union Security Insurance Company are authorized to write life, and accident and health insurance in Connecticut.

IV. MARKET CONDUCT REPORTS

The examiners reviewed copies of all market conduct examination reports issued to Time Insurance Company, John Alden Life Insurance Company and Union Security Life Insurance Company by other state insurance departments during the examination period. The reports were reviewed to ensure that corrective action was taken regarding all recommendations made by the respective Insurance Departments.

V. AGENCY ORGANIZATION

The Companies operate in Connecticut principally through the offices of independent producers.

The Companies maintain an ongoing training program for their agents. The Companies supply new producers with a product portfolio, which provides detailed descriptions of products and coverages. Changes in coverages mandated by statutes or the Companies' policies are communicated through written notices as they occur. In addition, the Companies host periodic training seminars for agents.

VI. RECORDS SELECTED FOR REVIEW

The Companies supplied a listing of all new business produced and claims processed during the period under review. A sample of three-hundred two (302) new business, cancellation, and declined contracts and three-hundred seventy two (372) claims were selected from the lists for review. The samples included accident and health contracts.

In addition, the producer and the application date for each policy in the samples were noted in order to identify any producers who were not properly licensed and appointed as required by Connecticut statutes. The licensing and appointment review is described in more detail in Section VII. below.

VII. PRODUCER LICENSING and APPOINTMENT

The lists of the new business written during the sample period, identifying the producer for each policy, were compared to the Department's licensing records to determine whether each producer was properly licensed in the state of Connecticut, and whether each individual was appointed by the Companies as required by Connecticut §§38a-702b., 38a-702l., and 38a-702m.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The Companies' records of licensed and appointed producers agree with Insurance Department's records.

Standard 2: Producers are properly licensed and appointed in the jurisdiction where the application was taken.

The following information was noted in conjunction with the review of this standard:

- The Companies maintain an automated producer database that interfaces with new business processing, policy maintenance and producer compensation.
- The Companies perform background checks and other due diligence procedures on individuals prior to contracting with them.
- The Companies' appointment procedures are designed to comply with the Department's requirements, which mandate that an agent must be appointed within 15 days from the date the Companies receive the application.

Findings:

Comparisons were made between the Companies' records of licensed/appointed producers and the Insurance Department's records. A review of the Companies' records found certain producers selling, soliciting or negotiating coverage without proper license and/or appointment.

Standard 3: Termination of producers complies with applicable standards, rules and regulations regarding notification to the producer and notification to the state, if applicable.

The Companies have procedures to provide notification of termination to the Department.

Findings:

The examiners reviewed the Companies' termination lists and noted that the Companies failed to report five (5) agents terminated for cause during the exam period. Three (3) agents had a Connecticut insurance license during the exam period. It is recommended that the Companies review their termination for cause procedures to ensure compliance with Department statutes and regulations.

Standard 4: The Companies' policy for producer appointments and terminations does not result in unfair discrimination against certificate holders.

Findings:

The examiners noted no evidence of unfair discrimination against certificate holders as a result of producer appointments and terminations.

Standard 5: Records of terminated producers adequately document reasons for terminations.

Findings:

The examiners verified the listing of terminated agents and reviewed the reasons for termination for each agent.

In Summary:

It is recommended that the Companies review their licensing and appointment system to ensure that no new business is accepted from, nor commissions paid to, individuals acting as agents of the Companies when they are not properly licensed and appointed, as required by statute.

VIII. UNDERWRITING and RATING

New business files were reviewed to determine the use and accuracy of rating methodology, accuracy of issuance, consistent (non-discriminatory) practices and use of proper forms. The Companies' policies, forms and rates were reviewed for proper filing with the Insurance Department and compliance with applicable statutes and regulations.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The rates charged for the policy coverages are in accordance with filed rates, if applicable, or the companies rating plans.

The following information was noted in conjunction with the review of this standard:

- Rates are systematically computed based on applicant information and rating classification assigned.
- The Companies have written underwriting policies and procedures.
- The Companies provide copies of Department approved rates for the new business submissions reviewed during the examination period.

Findings:

See Additional Concerns in Section VIII. - Underwriting and Rating.

Standard 2: The Companies do not permit illegal rebating, commission cutting or inducements.

The following information was noted in conjunction with the review of this standard:

- The Companies have procedures to pay agent commissions in accordance with the Companies' approved written contracts.

Findings:

The examiners reviewed the Companies' policies and procedures and verified that controls are in place to monitor and prevent illegal rebating, commission cutting and inducements.

Standard 3: All forms, including contracts, riders, endorsement forms and certificates, are filed with the Insurance Department, if applicable.

The following information was noted in conjunction with the review of this standard:

- The Companies have compliance policies and procedures in place to review forms, rates, contract riders and endorsements.

Findings:

The Department has concerns regarding the Companies' failure to file amendment riders and mandated benefit forms for approval of certificates, Form 224, Form 225, Form 380, Form 390 and Form 553. The examiners found through a review of new business and claims that the Companies failed to include the required mandatory coverage for Connecticut mandated benefits. The Companies are not providing correct or up-to-date policy forms to members.

Standard 4: The Companies' underwriting practices are not to be unfairly discriminatory. The Companies adhere to applicable statutes, rules and regulations, and company guidelines in selection of risks.

The following information was noted in conjunction with the review of this standard:

- The Companies' policies and procedures prohibit unfair discrimination.
- Written underwriting guidelines are designed to reasonably assure consistency in the rating of policies.

Findings:

The Companies' underwriting practices do not appear to be discriminatory.

Standard 5: File documentation adequately supports decisions made.

The examiners reviewed the sample files selected for review to ensure that all files requested are available for review and sufficiently documented.

Findings:

The Companies' appear in compliance.

Standard 6: Policies and endorsements are issued or renewed accurately, timely and completely.

The examiners reviewed the sample new business and renewal files to ensure that the Companies' underwriting policies and procedures were consistently applied for each sample file reviewed.

Findings:

See Additional Concerns in Section VIII. - Underwriting and Rating.

Standard 7: Applications rejected and not issued are not found to be discriminatory.

The Companies' underwriting policies and procedures prohibit unfair discrimination.

Findings:

The examiners reviewed one hundred (100) rejected applications and no exceptions were noted.

Standard 8: Cancellation/non-renewal notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract.

The Companies have procedures in place for the issuance of cancellation and renewal notices.

Findings:

The examiners reviewed ninety (90) cancellation files and no exceptions were noted.

Standard 9: Pertinent information on applications that form a part of the policy are complete and accurate.

Findings:

The examiners reviewed the sample new business files and no exceptions were noted.

Standard 10: Companies comply with the provisions of COBRA and/or continuation of benefits procedures contained in policy forms, statutes, rules and regulations.

The examiners reviewed the Companies' procedures for providing information pertaining to continuation of benefits for processing applications, and for notification to policy-holders of the beginning and termination of benefit periods and premium notices.

Findings:

The examiners reviewed the Companies' underwriting procedures and sample new business files and no exceptions were noted.

Standard 11: The Companies comply with the provisions of HIPAA and state law regarding limits on the use of pre-existing exclusions.

Findings:

See Additional Concerns in Section XII. - Claims.

Standard 12: The Companies issue coverage that complies with guaranteed issue requirements of HIPAA and related state laws for groups of 1 to 50.

Findings:

See Additional Concerns in Section VIII. - Underwriting and Rating.

Standard 13: The Companies refer eligible individuals entitled to portability under the provisions to HRA.

Findings:

The examiners verified that the Companies have procedures in place for individuals eligible for HRA and the examiners found no exceptions for the small group new business sample files reviewed.

Additional Concerns:

The Department has concerns that the Companies failed to ensure that sole proprietors and/or self-employed individuals were issued group certificates, and complied with Connecticut small group requirements. Although the Companies require individuals to attest that they are self-employed and that their premium will not be paid from their

business account, the Department found instances where the Companies accepted premium payments drawn from self-employed individual business bank accounts.

The Department has requested, as part of the corrective action plan, that the Companies distribute updated Amendment forms to their in-force customers, amend their marketing materials and provide education to their distribution channels that the association non-employer sponsored plans may not be marketed to sole proprietors and/or self-employed individuals. Additionally, the Companies filed true individual policies with the Department, which are pending approval.

In Summary:

The Department is concerned that the Companies failed to include the required mandatory coverages for Connecticut mandated benefits. In addition, the Companies are not providing correct or up-to-date policy forms to members. The Companies have recently had Amendments approved to update the certificate forms with the applicable mandates. Additionally, the Companies filed true individual policies with the Department, which are pending approval.

As noted above, the Department has requested, as part of the corrective action plan, that the Companies, distribute updated Amendment forms to their in-force customers, amend their marketing materials and provide education to their distribution channels that the association non-employer sponsored plans may not be marketed to sole proprietors and/or self-employed individuals.

IX. POLICYHOLDER SERVICE

New business files and policy transactions were reviewed for accuracy and timeliness of handling.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: Premium notices and billing notices are sent out with an adequate amount of advance notice.

The following information was noted in conjunction with the review of this standard:

- Verification that billing notices are generated automatically based on contract renewal dates and payment cycles.
- If premiums are not received, as required, an overdue premium notice is mailed noting that non-payment will cause the policy to lapse.

Findings:

The examiners reviewed the Companies' policies and procedures and no identifiable occurrences were noted.

Standard 2: Policy issuance and insured requested cancellations are timely.

The following information was noted in conjunction with the review of this standard:

- When the certificate holder requests cancellation, the cancellation is processed and any premium due is provided to the certificate holder.
- The Companies' policies are to provide written notice to the certificate holders when the Companies cancel for non-payment of premium.

Findings:

The examiners verified that the Companies have procedures in place to process certificate holder requested cancellations. The Companies' cancellations and such transactions appear to be processed in a timely manner.

Standard 3: All communication directed to the Companies is answered in a timely and responsive manner by the appropriate department.

The following information was noted in conjunction with the review of this standard:

- The Companies have customer call centers to respond to certificate holder and member concerns.

Findings:

The examiners reviewed the Companies' policies and procedures and no exceptions were noted.

Standard 4: Reinstatement is applied consistently and in accordance with policy provisions.

The Companies have standardized reinstatement guidelines in place to ensure that requests are reviewed and either approved or denied by underwriting.

Findings:

The examiners reviewed the Companies' policies and procedures. After reviewing the sample files, no exceptions were noted.

Standard 5: Policy transactions are processed accurately and completely.

The Companies have policies and procedures in place for processing certificate holder transactions including conversions, plan changes and enrollment updates.

Findings:

The examiners reviewed the Companies' transaction procedures through a sampling of new business files and no exceptions were noted.

Standard 6: Evidence of creditable coverage is provided in accordance with the requirements of HIPAA and/or statutes, rules and regulations.

The Companies have policies and procedures in place for tracking and issuing evidence of creditable coverage.

Findings:

See Additional Concerns in Section XII. - Claims.

X. MARKETING AND SALES

The marketing and sales materials were analyzed to identify any piece, which had a tendency to mislead or misrepresent any aspect of the Companies' products or benefits to certificate holders. In addition, the Department reviewed a sample of sixty (60) marketing and sales material advertisements to verify compliance with statutes and regulations related to the disclosure of certain information regarding the Companies' identities, financial standings and organization. Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

The following information was noted in conjunction with the review of this standard:

- Written policies and procedures govern the advertising and sales material process.
- All advertising and sales materials are reviewed in a consistent format through an online submission and tracking process.
- All advertising and producer generated material is subject to compliance review.

- Prior to final approval, all advertising and sales materials are reviewed to ensure that any necessary changes identified during the initial review were made.
- Approved submissions are endorsed for use for a specific period, which is incorporated into the approval number on the piece.

Findings:

It is recommended that the Companies ensure that all of their advertising materials comply with all disclosure requirements as required by Connecticut statutes and regulations. The Companies have agreed to revise the wording of the Health Advocates Alliance brochures.

Standard 2: The Companies' internal producer training materials are in compliance with applicable statutes, rules and regulations.

The Companies have developed training programs for their producers.

Findings:

The examiners reviewed the Companies' training programs, and established policies and procedures. The Companies' internal producer training materials appear to be in compliance.

Standard 3: The Companies' communications to producers are in compliance with applicable statutes, rules and regulations.

Findings:

The Companies maintain an on-going training program. Written policies and procedures govern that all communications are reviewed and approved by the Companies' Legal Units.

Standard 4: Outline of coverage is in compliance with applicable statutes, rules and regulations.

Findings:

The Companies appear to be in compliance.

In Summary:

It is recommended that the Companies review their policies and procedures to ensure that all of their advertising materials comply with all disclosure requirements as required by Connecticut statutes and regulations.

XI. COMPLAINTS

The Department's complaint records and the Companies' complaint records were reviewed to locate any allegations of misrepresentation against the Companies' agents or any other adverse trends.

Twenty-three (23) Department complaints were reviewed along with one hundred twelve (112) Non-Department complaints.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: All complaints or appeal/grievances are recorded in the required format on the Companies' complaint registers.

The following information was noted in conjunction with the review of this standard:

- Written policies and procedures govern the complaint handling process.
- All complaints are recorded in a consistent format in the complaint log.
- An automated tracking database is used to record and maintain complaint information.

Findings:

The examiners reviewed the selected files and no exceptions were noted.

Standard 2: The Companies have adequate complaint handling procedures in place and communicate such procedures to certificate holders.

The following information was noted in conjunction with the review of this standard:

- The Companies' Plan Descriptions have been reviewed and approved by the Department.
- The complaint handling procedures are included in the Plan Descriptions.

Findings:

The examiners verified that the Companies have complaint procedures in place as required by statute.

Standard 3: The Companies should take adequate steps to finalize and dispose of Department complaints in accordance with applicable statutes, rules and regulations, and contract language.

Findings:

The examiners found no instances where complaints were not responded to in a reasonable timeframe.

Standard 4: The time frame within which the Companies respond to complaints, grievances and appeals is in accordance with applicable statutes, rules and regulations.

Findings:

The examiners verified that the initial communication with the certificate holder was timely. The resolution of the cases, depending on the complexity, were resolved in a reasonable time period.

Additional Concerns:

In addition, the examiners have the following concerns:

- The examiners noted, through a review of Department complaints, that the Company processed a claim for physical therapy in error. The examiners requested the Company provide a list of any other claims that may have been processed in error. The Company provided a list of thirteen (13) claims that should have been paid. The examiners have requested that the Company reprocess the claims including interest and letters be sent to the certificate holders acknowledging the Department's findings. The Department suggests the Company review its claim policies and procedures for physical therapy reimbursement.

- The examiners identified some concerns through a review of Department complaints regarding the Companies processing of ambulance service claims. The Department was advised that the effective January 1, 2009 covered charges were based on the 95th percentile for all product forms.

- The examiners noted through a review of Department complaints that one (1) prescription contraceptive claim was denied in error. The examiners requested a review of all contraceptive denials on policies that contained prescription drug coverage and the review revealed that the Companies failed to process sixty-four (64) claims for approximately $11,061, not including interest. The Department has requested that these claims be re-adjudicated with interest and letters be sent to the certificate holders acknowledging the Department's findings. The Department is concerned that the Companies failed to adopt reasonable standards for the prompt investigation of claims.

In Summary:

It is recommended that the Companies review their policies and procedures to ensure that all complaints, appeals and grievances are properly investigated and resolved pursuant to required complaint and claim handling requirements. In addition, all claims requiring remediation have been identified and paid with interest, if applicable, and provided a letter acknowledging the Department's findings.

XII. CLAIMS

The Companies provided a listing of all claims paid during the period under examination. The review consisted of a sampling of paid and denied claims closed during the examination period. Three hundred seventy-two (372) claim files were selected at random for review. The files were reviewed to determine the accuracy and timeliness of claim payments, and interest payable on proceeds was recalculated to verify the accuracy of the Companies' calculations and payments.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The initial contact by the Companies with the claimant is within the required time frame and claims are settled in a timely manner.

The following information was noted in conjunction with the review of this standard:

- Written policies and procedures govern the claim handling process.
- All claim notifications are logged into the claim system.
- Claim management monitors claim accuracy and timeliness.

Findings:

Pursuant to §38a-816(15) of the Connecticut General Statutes, the Companies are required to pay clean claims within forty-five (45) days of proof of loss. The Department requested that the Companies provide a listing of all clean claims paid in excess of forty-five (45) days of proof of loss for the examination period. The examiners found 1,398 clean claims that were not paid within forty-five (45) days of receipt of the proof of loss due to legitimate disputes during the examination period. In addition, the examiners found 137 claims that were not paid within forty-five (45) days of receipt of the proof of loss, which failed to include interest. It is recommended that the Companies review their claim handling procedures to ensure that all claims are investigated and resolved pursuant to required claim settlement practices and in accordance with Connecticut Insurance Code, Sections 38a-816(6), 38a-816(15) (A) (B) and 38a-477.

Standard 2: Claim files are adequately documented.

The following information was noted in conjunction with the review of this standard:

- Copy of the HCFA form or electronic proof of loss.
- Applicable clinical/other investigative correspondence.
- Written communication, telephone or other communication.
- Proof of payment.

Findings:

See additional concerns in Section XII. - Claims.

Standard 3: The Companies have appropriate policies in place for the archival and disposal of claim forms.

Findings:

The examiners reviewed the policies and procedures and no identifiable occurrences were found.

Standard 4: The Companies' claim forms are appropriate for the type of product.

Findings:

The examiners noted that the claim forms were appropriate and in accordance with the Companies' policies and procedures.

Standard 5: Canceled benefit checks and drafts reflect appropriate claim handling practices.

The following information was noted in conjunction with the review of this standard:

- Claim procedures were verified to ensure that the check/draft claim process was handled accurately and was appropriate.

Findings:

The examiners noted that sampled claim payments were appropriate and in accordance with the Companies' policies and procedures.

Standard 6: Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.

The following information was noted in conjunction with the review of this standard:

- A review of all litigated claims for the examination period was conducted and no exceptions were noted.

Findings:

The examiners reviewed the policies and procedures and no identifiable occurrences were found. Specific claim errors are identified below.

Additional Concerns:

In addition to the standards reviewed in this section, the examiners have the following concerns:

- The examiners noted the Company denied one (1) claim for "subject to waiting period", in error. The examiners requested that the Company reprocess the claim including interest and send a letter to the certificate holder acknowledging the Department's findings. The Department is concerned that claims are denied without sufficient investigation.

- Out of a sample of one hundred sixty-five (165) pre-existing claim files, the examiners found the Companies were unable to provide sufficient documentation for five (5) sample pre-existing condition claim files. Upon review of the five (5) files in preparation for the examination, the Companies

determined that adequate documentation no longer existed to maintain their original decision, so the claim was referred for reprocessing.

- The examiners found one (1) instance in which the Company overturned a sample pre-existing condition claim file. The Company responded that during a Market Conduct Examination conducted in 2007, the Company changed their procedure where the Company would no longer determine a condition to be pre-existing if the insured disclosed the condition on the enrollment form.

  In addition, the examiners identified that the Companies do not ask prior coverage information at the time of application for student medical plans resulting in claims being denied and then overturned after the requested information and copies of credible coverage are received. The Department is concerned with the Companies' failure to investigate claims when first received.

- The examiners noted in a review of Student Health Claims that it appeared the Companies had not filed an approved contract since April 26, 1995 or any other mandated benefit forms for approval. The Companies advised that they provided a list of fifteen (15) claims that were denied in error. The examiners verified that the Companies reprocessed the claims including interest and issued a letter to the certificate holders acknowledging the Department's findings. The examiners are concerned that the certificate holders have not been provided up-to-date certificate forms.

- The examiners noted the Companies reprocessed two (2) claims that were previously denied as pre-existing condition claims after the expiration of the 12 month pre-existing exclusion period. The Companies did not conduct a review until after the Department became involved. The Department verified the Companies made payments on July 16, 2009, including interest.

- The examiners found twenty-two (22) instances where the Companies sent information regarding John Alden Life Insurance Claims on Time Insurance Company letterhead. The Companies confirmed that all letters will be on Assurant Health stationery referencing the underwriting company as John Alden Life Insurance Company or Time Insurance Company. In addition, the Explanation of Benefit statements and Remittance Advices will now print with the name of the underwriting company.

- The examiners noted that in twenty-three (23) instances, Time Insurance Company's medical claims were denied because repricing information was not submitted; however in four (4) instances, the repricing information was attached and the claims were denied in error. The Department is concerned that the Company's process resulted in unnecessary delays in processing the claims.

- The examiners found four (4) claims for Time Insurance Company which were denied in error; the Company has reprocessed the claims. The Department is concerned that the Company did not properly investigate the claims at the time they were originally received.

- The examiners found one (1) Time Insurance Company claim that was denied twice because of a contract exclusion. The claimant had to submit the claim to the grievance panel to have the claim overturned. The Company was asked to review claims for similar denials during our examination period and the review showed that there were no additional claims denied during the examination period. The Department requested that the Company revise its claims procedures so that this exclusion, which is already in their certificates, does not conflict with the Connecticut requirements.

- In reviewing denied claims, the examiners found several certificates which contained Special Exception Riders (SERs). The Department is concerned that the Companies issued SERs to certificate holders relating to infertility and failed to comply with Connecticut requirements. The Department asked the Companies to review all infertility claims denied in error from 10/01/05 through the current date. The Department identified that five (5) infertility claims that were denied in error were a result of a Special Exception Rider. The Department requested that the Special Exception Riders relating to infertility be removed from all certificates.

- The examiners noted that the Company incorrectly processed a claim for wig reimbursement as out-of-network instead of in-network. The Company provided a list of two (2) claims that should have been paid as in-network. The examiners have requested the Company reprocess these claims with interest, and that letters be sent to the certificate holders acknowledging the Department's findings. The Department suggests the Company review its claim policies and procedures to ensure proper investigation and payment of claims.

Summary:

It is recommended that the Companies review their claim handling procedures to ensure that all claims are investigated, processed and resolved pursuant to required claim settlement practices. In addition, it is recommended that the Companies review their policies and procedures to ensure that all claim information is documented sufficiently for regulatory review.

XIII. NETWORK ADEQUACY

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The health carrier files a quality assurance plan with the Commissioner for each managed care plan that the carrier offers in the State, and files updates whenever it makes a material change to an existing managed care plan. The carrier makes the quality assurance plans available to regulators.

The following information was noted in conjunction with the review of this standard:

- The Companies' procedures for making referrals within and outside their network.
- The Companies' methods for assessing the health care needs of covered persons and their satisfaction with services.
- The Companies' systems for ensuring the coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning.

Findings:

The examiners noted that guidelines in place appear to be appropriate.

Standard 2: The health carrier files with the Commissioner all required contract forms and any material changes to a contract, proposed for use with its participating providers and intermediaries.

Findings:

The examiners noted that guidelines in place appear to be appropriate.

Standard 3: The health carrier executes written agreements with each participating provider that is in compliance with statutes rules and regulations.

Findings:

The examiners noted that guidelines in place appear to be appropriate and no exceptions were noted.

Standard 4: The health carrier's contracts with intermediaries are in compliance with statutes, rules and regulations.

The following information was noted in conjunction with the review of this standard:

- The Companies' statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.
- A company shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.
- The Companies shall maintain copies of all intermediary health care subcontracts at their principal place of business in the state, or ensure that they have access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review.

Findings:

The examiners noted that guidelines in place appear to be appropriate and no exceptions were noted.

Standard 5: The health carrier provides notice to members advising them of Primary Care Physicians who have terminated with the plan as required by Connecticut Statute.

The following information was noted in conjunction with the review of this standard:

- The Companies have developed selection standards for primary care professionals and each health care professional specialty.
- The standards are used in determining the selection of health care professionals by the health carrier, its intermediaries and any provider networks with which it contracts.

Findings:

The examiners noted that guidelines in place appear to be appropriate and no exceptions were noted.

Standard 6: The health carrier provides, at enrollment, a Provider Directory listing all providers participating in its network. It also makes available, on a timely and reasonable basis, updates to its directory.

Findings:

See additional concerns on Section XII. page 19.

XIV. PROVIDER CREDENTIALING

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The health carrier establishes and maintains a program for credentialing and recredentialing in compliance with statutes, rules and regulations.

The following information was noted in conjunction with the review of this standard:

- The Companies have established written policies and procedures for credentialing and re-credentialing verification of all health care professionals with whom the health carrier contracts and shall apply those standards consistently.
- The Companies have assured that the carrier's medical director or other designated health care professional shall have responsibility for, and shall participate in, the health care professional credentialing verification.
- The Companies have established a credentialing verification committee consisting of licensed physicians and other health care professionals to review credentialing verification information and supporting documentation.

Findings:

The examiners noted that the Companies have delegated the credentialing to two (2) PPO intermediaries; Northeast Healthcare Alliance and Private Healthcare Systems.

Standard 2: The health carrier verifies the credentials of a health care professional before entering into a contract with that health care professional.

The following information was noted to ensure providers are properly credentialed prior to appearing in the provider directory.

Findings:

The examiners noted that the Companies have delegated the credentialing to two (2) PPO intermediaries; Northeast Healthcare Alliance and Private Healthcare Systems. No exceptions were noted.

Standard 3: The health carrier requires all participating providers to notify the health carrier's designated individual of changes in the status of any information that is required to be verified by the health carrier.

Findings:

The examiners noted that guidelines in place appear to be appropriate and no exceptions were noted.

Standard 4: The health carrier provides a health care professional the opportunity to review and correct information submitted in support of that health care professional's credentialing verification.

Findings:

The examiners noted that guidelines in place appear to be appropriate and no exceptions were noted.

XV. COMPANY OPERATIONS

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The Companies have up-to-date, valid internal or external, audit programs.

The following information was noted in conjunction with the review of this standard:

- The Companies have an internal audit department that has performed reviews of a variety of operational functions.
- Audit reports are distributed to all relevant operational and management personnel.
- External audits are performed on a regular basis.

Findings:

The Companies appear to be in compliance.

Standard 2: The Companies have appropriate controls, safeguards and procedures for protecting the integrity of computer information.

The following information was noted in conjunction with the review of this standard:

- The Companies have procedures in place for all operational functions.
- System tests are performed on a regular basis.

Findings:

The examiners reviewed and verified that the Companies have a program in place to protect the integrity of computer information.

Standard 3: The Companies have anti-fraud plans in place.

The following information was noted in conjunction with the review of this standard:

- The Companies have written antifraud plans.
- The Companies have Special Investigative Units (SIU).
- Potential fraud activity is tracked by the SIU and investigated.

Findings:

The Companies appear to be in compliance. No exceptions were noted.

Standard 4: The Companies have valid disaster recovery plans.

Findings:

The examiners verified that the Companies have valid disaster recovery programs in place and no exceptions were reported.

Standard 5: Records are adequate, accessible, consistent and orderly, and comply with record retention requirements.

Findings:

The Companies have previously submitted a modified retention policy and schedule in accordance with the Corrective Action Plan resulting from the previous Market Conduct examination. The Companies appear to be in compliance.

Standard 6: The Companies are licensed for the lines of business that are being written.

Findings:

The examiners reviewed the certificate of authority for each Company and compared it to the lines of business that the Companies write in the State of Connecticut.

Standard 7: The Companies have procedures for the collection, use and disclosure of information gathered in connection with insurance transactions so as to minimize any improper intrusion into the privacy of applicants and certificate holders.

The following information was noted in conjunction with the review of this standard:

- The Companies' policies allow for sharing customer and personal information with affiliates, but do not share such information with non-affiliates.
- The Companies' policies require a consumer privacy notice to be provided to certificate holders on an annual basis.
- The Companies have developed and implemented information technology security practices to safeguard the customer's personal and health information.
- The Companies' internal audit function conducts reviews of privacy policies and procedures.

Findings:

The Companies appear to be in compliance.

Standard 8: The Companies cooperated on a timely basis with the examiners performing the examination.

Findings:

The Department received cooperation from the Companies throughout the examination process.

XVI. SUMMARY OF RECOMMENDATIONS

Report
Section

VII. Producer Licensing and Appointment:

It is recommended that the Companies review their licensing and appointment systems to ensure compliance with current licensing and appointment requirements.

VIII. Underwriting and Rating:

The Department is concerned that the Companies failed to include the required mandatory coverages for Connecticut mandated benefits in their certificates as required by Connecticut Statutes. In addition, the Companies are not providing correct or up-to-date policy forms to members.

The Companies have recently had Amendments approved to update the certificate forms with the applicable mandates. Additionally, the Companies filed true individual policies with the Department, which are pending approval.

As noted above, the Department has requested, as part of the corrective action plan, that the Companies distribute updated Amendment forms to their in-force customers, amend their marketing materials and provide education to their distribution channels that the association non-employer sponsored plans may not be marketed to sole proprietors and/or self-employed individuals.

X. Marketing and Sales:

It is recommended that the Companies review their policies and procedures to ensure that all of their advertising materials comply with all disclosure requirements as required by Connecticut statutes and regulations.

XI. Complaints:

It is recommended that the Companies review their policies and procedures to ensure that all complaints, appeals and grievances are properly investigated and resolved pursuant to required complaint and claim handling requirements. In addition, all claims requiring remediation have been identified and paid with interest (if applicable), and provided a letter acknowledging the Department's findings.

XII. Claims:

It is recommended that the Companies review their claim handling procedures to ensure that all claims are investigated, processed and resolved pursuant to required claim settlement practices. In addition, it is recommended that the Companies review their policies and procedures to ensure that all claim information is documented sufficiently for regulatory review.

XVII. ACKNOWLEDGMENT

The courtesy and cooperation of Time Insurance Company, John Alden Life Insurance Company and Union Security Insurance Company during the course of the examination is acknowledged.

Steve DeAngelis, Christine Cormier and Meg Salamone participated in the preparation of this report.

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

---------- x

IN THE MATTER OF: DOCKET MC 10-89

TIME INSURANCE COMPANY :

---------- x

STIPULATION AND CONSENT ORDER

It is hereby stipulated and agreed between Time Insurance Company and the State of Connecticut by and through Barbara C. Spear, Acting Insurance Commissioner, to wit:

I

WHEREAS, pursuant to an examination, the Commissioner alleges the following with respect to Time Insurance Company.

1. Time Insurance Company, hereinafter referred to as Respondent, is domiciled in the State of Wisconsin and is licensed to transact the business of life, health and accident in the State of Connecticut under license number 69477.

2. From June 22, 2009 through April 5, 2010, the Department conducted an examination of Respondent's market conduct practices in the State of Connecticut covering the period from January 1, 2006 through March 31, 2009.

3. During the period under examination, Respondent failed to establish effective practices and procedures to ensure compliance with statutory requirements, resulting in instances of:

    a. producers soliciting, negotiating or effecting coverage on Respondent's behalf without proper license and/or appointment.

    b. failure to pay claims within 45 days.

    c. failure to pay interest on claims not paid within 45 days.

    d. failure to pay claims without conducting a reasonable investigation.

    e. failure to pay claims as required by Connecticut mandated benefits.

f. failure to include the required mandatory coverage for Connecticut mandated benefits as required by Connecticut Statutes.

g. insufficient documentation for regulatory review.

h. failure to file mandated benefit forms and amendment riders with the Department.

i. failure to implement proper controls to ensure sole proprietors and self-employed individuals comply with Connecticut small group requirements.

4. The conduct, as described above, violates §§38a-478m., 38a-509, 38a-566, 38a-567, 38a-702l., 38a-702m., 38a-782, 38a-815 and 38a-816 of the Connecticut General Statutes; §§38a-478u-6 and 38a-819-5 of the Regulations of Connecticut State Agencies; and constitutes cause for the imposition of a fine or other administrative penalty under §§38a-2, 38a-41, 38a-774 and 38a-817 of the Connecticut General Statutes.

II

1. WHEREAS, Respondent neither admits nor denies the allegations contained in paragraphs three and four of Article I of this Stipulation; and

2. WHEREAS, Respondent agrees to undertake a complete review of its practices and procedures to bring the areas of concern, as described in the Market Conduct Report and this Stipulation, into immediate compliance with Connecticut Statutes; and

3. WHEREAS, Respondent agrees to provide the Insurance Commissioner with a full report of finding and a summary of corrective actions taken at the Respondent's expense, in a manner, form and level of detail satisfactory to the Department, to comply with the requirements of paragraph two of this section within ninety (90) days of the date of this document; and

4. WHEREAS, Respondent agrees that all Special Exception Riders affecting required mandated benefits will be removed from the certificates and that the Company will re-file with the Department amendments that remove the infertility exclusion currently in place on all certificates.

5. WHEREAS, Respondent agrees to pay a fine in the amount of $318,000 for the violations described herein: and

6. WHEREAS, Respondent, being desirous of terminating this proceeding without the necessity of a formal proceeding or further litigation, does consent to the making of this Consent Order and voluntarily waives:

    a. any right to a hearing; and

    b. any requirement that the Insurance Commissioner's decision contain a statement of findings of fact and conclusion of law; and

    c. any and all rights to object to or challenge before the Insurance Commissioner or in any judicial proceeding any aspect, provision or requirement of this Stipulation.

NOW THEREFORE, upon the consent of the parties, it is hereby ordered and adjudged:

1. That the Insurance Commissioner has jurisdiction of the subject matter of this administrative proceeding.

2. That the Company will provide a report of findings, as outlined in paragraph three of Section II.

3. That Respondent is fined the sum of three hundred eighteen thousand dollars ($318,000) for the violations herein above described.

By: _____

CERTIFICATION

The undersigned deposes and says that he/she has duly executed this Stipulation and Consent Order on this 10th day of December 2010 for and on behalf of Time Insurance Company that he/she is the Vice President Regulatory Compliance of such company, and he/she has authority to execute and file such instrument.

By: _____

State of Wisconsin

County of Milwaukee

Personally appeared on this 10th day of December 2010, Christine R Fleming signer and sealer of the foregoing Stipulation and Consent Order, acknowledged same to be his/her free act and deed before me.

_____ Commission expires 3/25/12
Notary Public/Commissioner of the Superior Court

Section Below To Be Completed by State of Connecticut Insurance Department

---

Dated at Hartford, Connecticut this 29th day of December 2010.

_____
Barbara C. Spear
Acting Insurance Commissioner